BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Moshen T. Moghaddam, M.D. Physician's and Surgeon's Certificate No. A 46373 Respondent.	Case No. 800-2018-042453

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on APR 21 2022.

IT IS SO ORDERED APR 14 2022.

MEDICAL BOARD OF CALIFORNIA

for: William Prasifka
Executive Director

Reji Varghese
Deputy Director

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
Deputy Attorney General
State Bar No. 173955
300 So. Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6538
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MOSHEN T. MOGHADDAM, M.D. 19100 Ventura Boulevard, Suite 16 Tarzana, California 91356-3234 Physician's and Surgeon's Certificate A 46373, Respondent.	Case No. 800-2018-042453 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Moshen T. Moghaddam, M.D. (Respondent) is represented in this proceeding by attorney Peter R. Osinoff of Bonne, Bridges, Mueller, O'Keefe & Nichols, 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071-1562.

///

3. On August 7, 1989, the Board issued Physician's and Surgeon's Certificate No. A 46373 to Moshen T. Moghaddam, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-042453 and will expire on December 31, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-042453 was filed before the Board and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on March 24, 2021. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-042453 is attached as Exhibit A and is incorporated by reference.

ADVISEMENT AND WAIVERS

5. In addition to the Accusation No. 800-2018-042453, the Board is currently conducting two additional investigations of complaints pertaining to Respondent, case numbers 800-2019-054896 and 800-2021-078617. Respondent has no prior record of discipline and wishes to retire from the practice of medicine. It is the intent of the parties that this Stipulated Surrender will resolve all disciplinary charges pending against Respondent as well as any potential disciplinary charges represented by the ongoing investigations.

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-042453. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

//

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands that the charges and allegations in Accusation No. 800-2018-042453, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

11. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

///

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED THAT Physician's and Surgeon's Certificate No. A 46373, issued to Respondent Moshen T. Moghaddam, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2018-042453 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. In addition, and notwithstanding any applicable period of limitations, if and/or when the Board determines whether to grant or deny any future petition for reinstatement by Respondent, the Board shall consider the circumstances of ongoing investigations 800-2019-054896 and 800-2021-078617, and admit into evidence in any reinstatement proceeding reports of investigation number 800-2019-054896 and 800-2021-078617 and any attachments thereto.

6. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $3,625 prior to issuance of a new or reinstated license.

7. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of

California, all of the charges and allegations contained in Accusation, No. 800-2018-042453 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure. The circumstances of the ongoing investigations 800-2019-054896 and 800-2021-078617, shall also be considered, and reports of investigation number 800-2019-054896 and 800-2021-078617, including any attachments thereto, shall be admitted into evidence of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Peter R. Osinoff, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 4-3-2022

MOSHEN T. MOGHADDAM, M.D.
Respondent

I have read and fully discussed with Respondent MOSHEN T. MOGHADDAM, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 4/6/2022

PETER R. OSINOFF
Attorney for Respondent

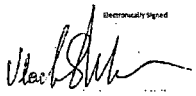
ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: April 7, 2022

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General



VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

LA2021600806
64988590.docx

Exhibit A

Accusation No. 800-2018-042453

MATTHEW RODRIQUEZ
Acting Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
COLLEEN M. MCGURRIN
Deputy Attorney General
California Department of Justice
State Bar No. 147250
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 269-6546
Facsimile: (916) 731-2117
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MOSHEN T. MOGHADDAM, M.D. 19100 Ventura Boulevard, Suite 16 Tarzana, California 91356-3234 Physician's and Surgeon's Certificate A 46373, Respondent.	Case No. 800-2018-042453 **ACCUSATION**

PARTIES

1. William Prasifka (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 7, 1989, the Board issued Physician's and Surgeon's Certificate Number A 46373 to Moshen T. Moghaddam, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2022, unless renewed.

//

//

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

5. Section 2234 of the Code states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2220 of the Code states:

Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes including, but not limited to:

(a) Investigating complaints from the public, from other licensees, from health care facilities, or from the board that a physician and surgeon may be guilty of unprofessional conduct. The board shall investigate the circumstances underlying a report received pursuant to Section 805 or 805.01 within 30 days to determine if an interim suspension order or temporary restraining order should be issued. The board shall otherwise provide timely disposition of the reports received pursuant to Section 805 and Section 805.01.

(b) Investigating the circumstances of practice of any physician and surgeon where there have been any judgments, settlements, or arbitration awards requiring the physician and surgeon or his or her professional liability insurer to pay an amount in damages in excess of a cumulative total of thirty thousand dollars ($30,000) with respect to any claim that injury or damage was proximately caused by the physician's and surgeon's error, negligence, or omission.

(c) Investigating the nature and causes of injuries from cases which shall be reported of a high number of judgments, settlements, or arbitration awards against a physician and surgeon.

7. Section 2228 of the Code states:

The authority of the board or the California Board of Podiatric Medicine to discipline a licensee by placing him or her on probation includes, but is not limited to, the following:

(a) Requiring the licensee to obtain additional professional training and to pass an examination upon the completion of the training. The examination may be written or oral, or both, and may be a practical or clinical examination, or both, at the option of the board or the administrative law judge.

(b) Requiring the licensee to submit to a complete diagnostic examination by one or more physicians and surgeons appointed by the board. If an examination is ordered, the board shall receive and consider any other report of a complete diagnostic examination given by one or more physicians and surgeons of the licensee's choice.

(c) Restricting or limiting the extent, scope, or type of practice of the licensee, including requiring notice to applicable patients that the licensee is unable to perform the indicated treatment, where appropriate.

(d) Providing the option of alternative community service in cases other than violations relating to quality of care.

8. Section 2241.5 of the Code states:

(a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

9. Section 2242 of the Code states:

(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. An appropriate prior examination does not require a synchronous interaction between the patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of the patient's practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

10. Section 725 of the Code states:

(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5.

11. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

12. Health and Safety Code section 11165 states:

(a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of

disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, if patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) The Department of Justice shall, no later than July 1, 2020, adopt regulations regarding the access and use of the information within CURES. The Department of Justice shall consult with all stakeholders identified by the department during the rulemaking process. The regulations shall, at a minimum, address all of the following in a manner consistent with this chapter:

(A) The process for approving, denying, and disapproving individuals or entities seeking access to information in CURES.

(B) The purposes for which a health care practitioner may access information in CURES.

(C) The conditions under which a warrant, subpoena, or court order is required for a law enforcement agency to obtain information from CURES as part of a criminal investigation.

(D) The process by which information in CURES may be provided for educational, peer review, statistical, or research purposes.

(4) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider

identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility, if provided.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (N.D.C.) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(11) The serial number for the corresponding prescription form, if applicable.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

(h) (1) The Department of Justice may enter into an agreement with any entity operating an interstate data sharing hub, or any agency operating a prescription drug monitoring program in another state, for purposes of interstate data sharing of prescription drug monitoring program information.

(2) Data obtained from CURES may be provided to authorized users of another state's prescription drug monitoring program, as determined by the Department of Justice pursuant to subdivision (c), if the entity operating the interstate data sharing hub, and the prescription drug monitoring program of that state, as applicable, have entered into an agreement with the Department of Justice for interstate data sharing of prescription drug monitoring program information.

(3) Any agreement entered into by the Department of Justice for purposes of interstate data sharing of prescription drug monitoring program information shall ensure that all access to data obtained from CURES and the handling of data contained within CURES comply with California law, including regulations, and meet the same patient privacy, audit, and data security standards employed and required for direct access to CURES.

(4) For purposes of interstate data sharing of CURES information pursuant to this subdivision, and authorized user of another state's prescription drug monitoring program shall not be required to register with CURES, if he or she is registered and in good standing with that state's prescription drug monitoring program.

(5) The Department of Justice shall not enter into an agreement pursuant to this subdivision until the department has issued final regulations regarding the access and use of the information within CURES as required by paragraph (3) of subdivision (c).

(i) This section shall remain in effect only until January 1, 2021, and as of that date is repealed.

13. Health and Safety Code section 11165.1 states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (D.E.A.) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the Department of Justice. Upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to electronically access information regarding the controlled substance history of a patient that is maintained by the Department of Justice. Upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under the practitioner's care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application to access information contained in the CURES database.

(ii) Failing to maintain effective controls for access to the patient activity report.

(iii) Having his or her federal D.E.A. registration suspended or revoked.

(iv) Violating a law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Accessing information for a reason other than to diagnose or treat his or her patients, or to document compliance with the law.

(C) An authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(D) Commencing no later than October 1, 2018, an approved health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist pursuant to subdivision (b) of Section 209 of the Business and Professions Code may use the department's online portal or a health information technology system that meets the criteria required in subparagraph (E) to access information in the CURES database pursuant to this section. A subscriber who uses a health information technology system that meets the criteria required in subparagraph (E) to access the CURES database may submit automated queries to the CURES database that are triggered by predetermined criteria.

(E) Commencing no later than October 1, 2018, an approved health care practitioner or pharmacist may submit queries to the CURES database through a health information technology system if the entity that operates the health information technology system can certify all of the following:

(i) The entity will not use or disclose data received from the CURES database for any purpose other than delivering the data to an approved health care practitioner or pharmacist or performing data processing activities that may be necessary to enable the delivery unless authorized by, and pursuant to, state and federal privacy and security laws and regulations.

(ii) The health information technology system will authenticate the identity of an authorized health care practitioner or pharmacist initiating queries to the CURES database and, at the time of the query to the CURES database, the health information technology system submits the following data regarding the query to CURES:

(I) The date of the query.

(II) The time of the query.

(III) The first and last name of the patient queried.

(IV) The date of birth of the patient queried.

(V) The identification of the CURES user for whom the system is making the query.

(iii) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(iv) The entity has entered into a memorandum of understanding with the department that solely addresses the technical specifications of the health information technology system to ensure the security of the data in the CURES database and the secure transfer of data from the CURES database. The technical specification shall be universal for all health information technology systems that establish a method of system integration to retrieve information from the CURES database. The memorandum of understanding shall not govern, or in any way impact or restrict, the use of data received from the CURES database or impose any additional burdens on covered entities in compliance with regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(F) No later than October 1, 2018, the department shall develop a programming

interface or other method of system integration to allow health information technology systems that meet the requirements in subparagraph (E) to retrieve information in the CURES database on behalf of an authorized health care practitioner or pharmacist.

(G) The department shall not access patient-identifiable information in an entity's health information technology system.

(H) An entity that operates a health information technology system that is requesting to establish an integration with the CURES database shall pay a reasonable fee to cover the costs of establishing and maintaining integration with the CURES database.

(I) The department may prohibit integration or terminate a health information technology system's ability to retrieve information in the CURES database if the health information technology system fails to meet the requirements of subparagraph (E), or the entity operating the health information technology system does not fulfill its obligation under subparagraph (H).

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) A request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

(g) For purposes of this sections, the following terms have the following meanings:

(1) "Automated basis" means using predefined criteria to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner or pharmacist.

(2) "Department" means the Department of Justice.

(3) "Entity" means an organization that operates, or provides or makes available, a health information technology system to health care practitioner or pharmacist.

(4) "Health information technology system" means an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for communication, decision making, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

(5) "User initiated basis" means an authorized health care practitioner or pharmacist has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner or pharmacist.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

14. Health and Safety Code section 11165.4 states:

(a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's-controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, first time means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(h) This section shall become inoperative on July 1, 2021, or upon the date the department promulgates regulations to implement this section and posts those

regulations on its internet website, whichever date is earlier, and, as of January 1, 2022, is repealed.

15. Section 2228.1 of the Code provides as follows:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

(A) The commission of any act of sexual abuse, misconduct, or relations with a patient or client as defined in Section 726 or 729.

(B) Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely.

(C) Criminal conviction directly involving harm to patient health.

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendre1 or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled, including consultations in inpatient facilities.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(4) The licensee does not have a direct treatment relationship with the patient.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

FACTUAL ALLEGATIONS

PATIENT 1

16. An inquiry into the care of Patient 1 commenced after a complaint was submitted to the Board by the daughter of Patient 1[1], which alleged that Respondent had been prescribing medications to her father for a period of more than two years even though Patient 1 was already under the care of an assisted living facility for his medical conditions and medication management. The daughter of Patient 1, who held a health care power of attorney for her father, stated that she had asked Respondent on numerous occasions to stop prescribing multiple medications to her father. However, Respondent had refused to stop prescribing medications to Patient 1, citing "social ties" as the reason to continue prescribing. This conduct, the daughter alleged, caused her father to have an increasing number of falling incidents. Additionally, the daughter alleged that her father's medical conditions could not be effectively managed while Respondent continued to prescribe medications. Patient 1 was prescribed the following

[1] The individual patients are referred to by numbers to protect patient privacy. Their identity will be disclosed to the Respondent in discovery.

medications by Respondent: Xanax, Dexedrine, Abilify, Ambien, nitroglycerin, opioids, and medication for diabetes (a condition which Patient 1 did not have).

17. The records provided by Respondent for Patient 1 total approximately 47 pages from the period beginning approximately October 15, 2015 through approximately March 5, 2018. Although Patient 1 had been a patient of Respondent's since approximately April 4, 2012, Respondent was unable to provide records for the dates between approximately April 4, 2012 through approximately October 15, 2015, as a result of the records having been destroyed. As such, there are no clinic notes or visits for the time period between approximately April 4, 2012 through approximately October 15, 2015. However, the CURES System recorded that controlled substances were prescribed to Patient 1 by Respondent from approximately April 9, 2012, to approximately March 6, 2018. According to CURES, Patient 1 was routinely prescribed by Respondent the following medications: Alprazolam 1 mg., Zolpidem Tartrate 10 mg., Dextroamphetamine Sulfate 15 mg., Tramadol 50 mg., Temazepam 30 mg., and Testosterone Cypionate 200 mg. According to records from the nursing home and other outside hospitals, Patient 1 was a 78-year-old male with a history of coronary artery disease, schizophrenia, anxiety, hypertension, hyperlipidemia, benign prostatic hypertrophy, multiple falls, and pressure ulcers.

18. The medical records from Respondent's office reveal illegible progress notes with minimal documentation regarding Patient 1's medical condition. For instance, it is impossible to ascertain the chief complaint or reason for the medical visit in the progress notes. The section of the progress note for current medications was left blank. Vital signs were not consistently documented. The physical examination portion of the progress notes is illegible, making it impossible to determine what was examined on the date of service. Lastly, the assessment and diagnosis sections were illegible, making it impossible to determine what was prescribed to the patient and for what specific indication. The documentation lacked any pain assessment, lacked any assessment to determine if there was a prior substance abuse history, and there was no indication in the medical records that Respondent ever evaluated a CURES report to determine if Patient 1 was being prescribed controlled substances by another physician. Further, a clear indication for prescribing the controlled substances was not documented. There was no evidence

in the medical records that Respondent had made any referrals or diagnostic studies related to prescribing the controlled substances for this patient.

19. The standard of care requires a medical history and physical exam, which includes an assessment of the patient's pain, including physical and psychological status and function; substance abuse history; history of prior pain treatments and assessment of any other underlying or coexisting conditions. Finally, it should include documentation of recognized medical indications for the use of controlled substances. A history and physical was not documented in any clinic visits by Respondent. The period between approximately April 4, 2012 through approximately October 15, 2015, had no corresponding medical records, although the CURES report for that time period noted that Respondent had prescribed or refilled approximately 62 prescriptions for controlled substances. There was no evidence that a substance abuse history was performed in the medical records. The records were consistently illegible and lacked documentation of clearly recognized medical indications for the use of controlled substances given the patient's medical conditions. The records fail to document a review of systems and the lack of a physical examination. There was no clear indication for Respondent's prescribing of controlled substances to treat Patient 1's known medical conditions.

20. The lack of a documented substance abuse history and lack of a review of systems and physical examination constitute an extreme departure from the standard of care. The prescribing of controlled substances without a clear medical indication for the controlled substance is also an extreme departure from the standard of care. The lack of medical records for an approximately three-and-a-half-year period during which a patient was prescribed approximately 62 controlled substances is an extreme departure from the standard of care.

21. The standard of care requires the medical records contain stated objectives that may include relief of pain or relief of the medical condition requiring controlled substances and/or improved physical or psychological function or ability to perform certain tasks or activities of daily living. This should also include any plans for further diagnostic evaluations and treatments, such as a rehabilitation program. The medical records for the period of approximately October 15, 2015 through approximately March 5, 2018, reflect repeated departures from the standard of care

given Respondent's failure to document a specific treatment plan for this patient. The medical records did not document any treatment plans and had no clear plan or objectives for the ongoing prescribing of controlled substances.

22. Respondent's failure to document a specific treatment plan for this patient constitutes repeated extreme departures from the standard of care. There was no evidence that Respondent ordered any additional diagnostic evaluations or treatment for the patient related to the indications for prescribing the numerous controlled substances.

23. The standard of care requires that the medical records document that the physician discussed the risks and benefits of using controlled substances and other treatment modalities. An actual written consent is not required but is recommended. There was no evidence in the medical records that Respondent discussed potential side effects and risks of controlled substances. There were no written consent forms noted in the medical records. Respondent's clinical notes do not indicate that the risks of controlled substances were discussed. This constitutes an extreme departure from the standard of care as there was no evidence in the medical records that Respondent discussed the potential side effects and risks of ongoing prescribing of controlled substances to Patient 1.

24. The standard of care requires the medical records reflect that the physician is periodically reviewing the course of treatment and his prescribing of controlled substances for the patient and making appropriate modifications in treatment based on the patient's progress or lack of progress. However, the medical records for Patient 1 fail to demonstrate that Respondent ever performed a periodic review on the patient's ongoing treatment with controlled substances even though the patient was prescribed multiple controlled substances over a period of approximately seven years.

25. Respondent's failure to perform periodic reviews of the patient's treatment and status over a period of approximately seven years in the setting of repeated prescribing and refilling of multiple controlled substances constitutes multiple extreme departures from the standard of care.

26. The standard of care requires the physician consider obtaining additional evaluations and consultations, especially with complex pain problems. Special attention should be given to

patients who are at risk for misusing their medication or have a history of drug addiction or substance abuse. Such patients require extra care and monitoring and documentation and consultation with an addiction medicine specialist and, if indicated, a pain management specialist. There is no evidence in the medical records that Respondent made any referrals or obtained a consultation related to prescribing the controlled substances for Patient 1. There is no evidence that Respondent had assessed the patient for any prior history of drug addiction or substance abuse. Additionally, there is no evidence that Respondent ever requested or reviewed a CURES report to determine if Patient 1 was being prescribed controlled substances by another physician.

27. Respondent's failure to obtain a consultation for Patient 1 was a simple departure from the standard of care. Respondent's failure to determine if the patient was prescribed controlled substances by another provider was an extreme departure from the standard of care. Respondent did not employ CURES to determine if a patient he continuously prescribed controlled substances to for more than approximately seven years was receiving controlled substances from other providers.

28. The standard of care requires a physician to maintain accurate and complete records, demonstrate a history and exam, evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed, and periodic review documentation. The medical records for all visits are largely illegible in all sections of the progress note. The review of systems and physical examination sections of the progress notes are also largely illegible and fail to document why the patient was being seen, what part of the physical examination was performed, and the specific assessment and plan of care for the patient. The records lacked medical indication for the medications prescribed over a period of approximately seven years.

29. It was an extreme departure from the standard of care to have failed to produce a medical record for Patient 1 that documented standard guidelines in the use of controlled substances.

30. Through inappropriate prescribing of controlled substances, Respondent caused harm to Patient 1. The inappropriate prescribing of controlled substances (in this case Xanax, Dexedrine, Ambien, and opioid medication) by Respondent, without proper justification or

medical indication for such substances led to placing Patient 1 at an unnecessarily increased risk for significant morbidity and mortality and potential harm given his pre-existing chronic medical conditions. Specifically, the following harm resulted. Patient 1 had a history of hypertension and coronary artery disease. He was prescribed multiple controlled substances that had a high potential for abuse and dependency, which most likely resulted in Patient 1 developing a dependency on multiple controlled substances that were unnecessarily prescribed. Additionally, medication such as Dexedrine can lead to increased blood pressure which could potentially lead to adverse effects in a patient with known hypertension and coronary artery disease. Patient 1 was harmed by the Respondent's inappropriate prescribing. Patient 1 unnecessarily developed a likely dependency on multiple controlled substances, which should not have been prescribed to him given the lack of medical justification or medical indication for inappropriately prescribing of such medications by Respondent.

PATIENT 2

31. Patient 2 was an adult female who had a history of insomnia, depression, anxiety, and back pain. On or about June 28, 2018, the patient was seen by Respondent for complaints of nasal blockage, back and neck pain, dermatitis, a swollen nose, and muscle spasms. From approximately 2016 to approximately 2018, Patient 2 was prescribed consistently the following medications by Respondent: Hydrocodone 10 mg., Alprazolam 1mg., and Zolpidem 10 mg.

32. Respondent failed to comply with the standard of care for prescribing controlled substances to Patient 2, who had a history of insomnia, depression, anxiety, and back pain. The standard of care under such circumstances requires a medical history and physical exam, which includes an assessment of the patient's pain, including physical and psychological status and function; substance abuse history; history of prior pain treatments and assessment of any other underlying or co-existing conditions. Finally, it should include documentation of recognized medical indications for the use of controlled substances.

33. A history and physical was not documented in any clinic visits by Respondent. A review of the Respondent's medical records for Patient 2 for the period between approximately February 1, 2016 through approximately June 30, 2018, provide no evidence that a substance

abuse history was performed. The records are consistently illegible and lack documentation of clearly recognized medical indications for the use of controlled substances given the patient's medical conditions. In addition, the medical records of Patient 2 show a lack of a review of systems and the lack of a suitable physical examination. There was no clear indication documented for Respondent's prescribing of controlled substances for treatment of Patient 2's known medical conditions.

34. The lack of a documented substance abuse history and lack of a review of systems and physical examination constitute an extreme departure from the standard of care. The prescribing of controlled substances without a clear medical indication for the controlled substance is an extreme departure from the standard of care.

35. The standard of care requires the medical records contain stated objectives that may include relief of pain or relief of the medical condition requiring controlled substances and/or improved physical or psychological function or ability to perform certain tasks or daily living activities. This should also include any plans for further diagnostic evaluations and treatments, such as a rehabilitation program.

36. From approximately February 1, 2016 through approximately June 30, 2018, the medical records fail to document a specific treatment plan for this patient. The medical records do not document any treatment plans or any clear plan or objectives for the ongoing prescribing of controlled substances.

37. Respondent's failure to document a specific treatment plan for this patient was an extreme departure from the standard of care. There was no evidence documented in the medical record for Patient 2 to support that Respondent ordered any additional diagnostic evaluations or treatment for the patient related to the indications for prescribing the numerous controlled substances.

38. The standard of care requires the medical records document that the physician discuss risks and benefits of using controlled substances and other treatment modalities. An actual written consent is not required but is recommended. There was no evidence in the medical records that Respondent discussed potential side effects and risks of controlled substances. There

were no written consent forms noted in the medical records. Respondent's clinical notes do not indicate that the risks of controlled substances were discussed. This is an extreme departure from the standard of care as there was no evidence in the medical records that Respondent discussed the potential side effects and risks of ongoing prescribing of controlled substances to Patient 2.

39. The standard of care requires that patient records reflect that the physician is periodically reviewing the course of treatment and his prescribing of controlled substances for the patient, and making appropriate modifications in treatment based on the patient's progress or lack of progress. The medical records on Patient 2 do not demonstrate that Respondent ever performed a periodic review on the patient's ongoing treatment with controlled substances even though the patient was prescribed multiple controlled substances over a period of approximately two years.

40. Respondent's failure over a period of approximately two years to perform periodic reviews of the patient's treatment and status in the setting of repeated prescribing and refilling of multiple controlled substances constitutes multiple extreme departures from the standard of care.

41. The standard of care requires that the physician consider obtaining additional evaluations and consultations, especially with complex pain problems. Special attention should be given to patients who are at risk for misusing their medication or have a history of drug addiction or substance abuse. Such patients require extra care and monitoring and documentation, and consultation with an addiction medicine specialist and, if indicated, a pain management specialist.

42. There is no evidence in the medical records that Respondent had made any referrals or obtained a consultation related to prescribing the controlled substances for this patient. There is no evidence that Respondent had assessed the patient for any prior history of drug addiction or substance abuse.

43. Respondent's failure to obtain a consultation related to prescribing controlled substances for Patient 2 was a simple departure from the standard of care.

44. The standard of care requires the physician must maintain accurate and complete records, demonstrating a history and exam along with evaluations and consultations, treatment

plans and objectives, informed consent, medications prescribed, and periodic review documentation.

45. The medical records and progress notes for all visits with Patient 2 are largely illegible in all sections of the progress note. Also, the review of systems and physical examination sections of the progress notes are illegible, so that a reader could not determine why the patient was being seen, what part of the physical examination was performed and what the specific assessment and plan of care was for the patient. In addition, the records lack medical indication for the medications prescribed over a period of approximately two years.

46. Respondent's failure to document standard guidelines in the use of controlled substances for Patient 2 was an extreme departure from the standard of care.

47. Through inappropriate prescribing of controlled substances, Respondent harmed Patient 2. The inappropriate prescribing of controlled substances (Hydrocodone 10 mg., Alprazolam 1mg., and Zolpidem 10 mg.) by Respondent, without proper justification or medical indication for such substances over a period of approximately three years, led to placing Patient 2, a patient with a history of depression, anxiety, and back pain at an unnecessarily increased risk for significant morbidity and mortality and potential harm, including accelerated progression of her pre-existing chronic medical conditions and ongoing dependency on controlled substances. Specific harm resulted from the Respondent's conduct. Patient 2 had a history of depression, anxiety, and back pain. She was prescribed multiple controlled substances by Respondent that had a high potential for abuse and dependency in a patient with multiple medical conditions who was at risk for exacerbation of said co-morbidities by taking unnecessarily prescribed controlled medications. This resulted in Patient 2 developing a dependency on multiple controlled substances that were prescribed without medical indication. The Respondent's inappropriate prescribing resulted in patient harm to Patient 2. Patient 2 unnecessarily developed a dependency on multiple controlled substances which should not have been prescribed to her given the lack of medical justification or medical indication for inappropriately prescribing of such medications by Respondent.

//

PATIENT 3

48. Patient 3 was an adult male patient with a history of insomnia, anxiety, dizziness, dermatitis, cellulitis, back pain, hypertension, hearing loss, depression, and benign prostate hypertrophy. The Respondent prescribed the following medications to Patient 3 on a consistent basis during the period from approximately 2015 to approximately 2018: clonazepam, hydrocodone, zolpidem, and Soma.

49. Under such circumstances, the standard of care requires a medical history and physical exam, which includes an assessment of the patient's pain, including physical and psychological status and function; substance abuse history; history of prior pain treatments and assessment of any other underlying or co-existing conditions. Finally, it should include documentation of recognized medical indications for the use of controlled substances. A history and physical was not documented in any clinic visits by Respondent. There was no evidence that a substance abuse history was performed in the medical records between approximately July 1, 2015, through approximately December 31, 2018. The records were consistently illegible and lacked documentation of clearly recognized medical indications for the use of controlled substances given the patient's medical conditions. The records showed a lack of a review of systems and the lack of a physical examination. There was no clear indication for Respondent's prescribing of controlled substances for treatment of Patient 3's known medical conditions.

50. The lack of a documented substance abuse history and lack of a review of systems and physical examination constitute an extreme departure from the standard of care. The prescribing of controlled substances without a clear medical indication for the controlled substance is an extreme departure from the standard of care.

51. The standard of care requires the medical records contain stated objectives that may include relief of pain or relief of the medical condition requiring controlled substances and/or improved physical or psychological function or ability to perform certain tasks or activities of daily living. This should also include any plans for further diagnostic evaluations and treatments, such as a rehabilitation program. The medical records from the period of approximately July 1, 2015 through approximately December 31, 2018, reflect repeated departures from the standard of

care given Respondent's failure to document a specific treatment plan for this patient. The medical records do not have a clear plan or objectives for the ongoing prescribing of controlled substances.

52. Respondent's repeated failure to document a specific treatment plan for this patient constitutes extreme departures from the standard of care. There was no evidence to support that Respondent ordered any additional diagnostic evaluations or treatment for the patient related to the indications for prescribing the numerous controlled substances.

53. The standard of care requires the medical records document that the physician discussed risks and benefits of the use of controlled substances along with other treatment modalities. An actual written consent is not required but is recommended. There was no evidence in the medical records that Respondent discussed potential side effects and risks of controlled substances. There were no written consent forms in the medical records.

54. Respondent's clinical notes do not indicate that the risks of controlled substances were discussed. This constitutes an extreme departure from the standard of care as there was no evidence in the medical records that Respondent discussed the potential side effects and risks of ongoing prescribing of controlled substances to Patient 3.

55. The standard of care requires the medical records reflect that the physician periodically review the course of treatment and prescribing of controlled substances for the patient and making appropriate modifications in treatment based on the patient's progress or lack of progress. The medical records on Patient 3 fail to demonstrate that Respondent ever performed a periodic review on the patient's ongoing treatment with controlled substances even though the patient was prescribed multiple controlled substances over a period of over approximately three years.

56. There were multiple extreme departures from the standard of care over a period of over approximately three years for failure to perform periodic reviews of the patient's treatment and status in the setting of repeated prescribing and refilling of multiple controlled substances.

57. The standard of care under such circumstances requires that a physician consider obtaining additional evaluations and consultations, especially with complex pain problems.

Special attention should be given to patients who are at risk for misusing their medication or have a history of drug addiction or substance abuse. Such patients require extra care and monitoring and documentation, and consultation with an addiction medicine specialist and, if indicated, a pain management specialist. There is no evidence in the medical records for Patient 3 that Respondent made any referrals or obtained a consultation related to prescribing the controlled substances for this patient. There is no evidence that Respondent had assessed the patient for any prior history of drug addiction or substance abuse.

58. Respondent's failure to obtain a consultation in this patient is a simple departure from the standard of care.

59. The standard of care requires the physician to maintain accurate and complete records, demonstrate a history and exam, evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed, and periodic review documentation. The medical records for all visits with Patient 3 are largely illegible in all sections of the progress note. The review of systems and physical examination sections of the progress notes are likewise largely illegible, making it impossible to determine why the patient was being seen, what part of the physical examination was performed and what the specific assessment and plan of care was for the patient. The records lacked medical indication for the medications prescribed over a period of over approximately three years.

60. Respondent's failure to document standard guidelines in the use of controlled substances for Patient 3 is an extreme departure from the standard of care.

61. In addition, the inappropriate prescribing of controlled substances (clonazepam, hydrocodone, zolpidem, and Soma) by Respondent to Patient 3, without adequate justification or medical indication for such substances over a period of approximately three years, harmed Patient 3 by placing him at an unnecessarily increased risk for significant morbidity and mortality and potential harm given his pre-existing chronic medical conditions. Patient 3 had a history of insomnia, anxiety, dizziness, dermatitis, cellulitis, back pain, hypertension, hearing loss, depression, and benign prostate hypertrophy. He was prescribed multiple controlled substances by Respondent that had high potential for abuse and dependency in a patient with multiple

medical conditions who was at risk for exacerbation of said co-morbidities by taking unnecessarily prescribed controlled medications. This resulted in Patient 3 developing a dependency on multiple controlled substances that were prescribed without medical indication. Patient 3 unnecessarily developed a dependency on multiple controlled substances that should not have been prescribed to him given the lack of medical justification or medical indication for inappropriate prescribing of such medications by Respondent.

PATIENT 4

62. Patient 4 was an adult female patient with a history of anxiety and back pain. Respondent prescribed the following medications to Patient 4 on a consistent basis over the period of approximately 2016 to approximately 2018: clonazepam and hydrocodone.

63. The standard of care under such circumstances requires a medical history and physical exam, which includes an assessment of the patient's pain, including physical and psychological status and function; substance abuse history; history of prior pain treatments, and assessment of any other underlying or co-existing conditions. Finally, it should include documentation of recognized medical indications for the use of controlled substances. A history and physical was not documented in any clinic visits by Respondent. Medical records for Patient 4 for the period between approximately January 1, 2016 through approximately June 30, 2018, provide no evidence that a substance abuse history was performed. The records are consistently illegible and lack documentation of clearly recognized medical indications for the use of controlled substances given the patient's medical conditions. The records also show a lack of a review of systems and the lack of a physical examination. There was no clear indication for Respondent's prescribing of controlled substances for treatment of Patient 4's known medical conditions.

64. The lack of a documented substance abuse history and lack of a review of systems and physical examination for Patient 4 constitute an extreme departure from the standard of care. The prescribing of controlled substances without a clear medical indication for the controlled substance also is an extreme departure from the standard of care.

65. The standard of care requires that the medical records contain stated objectives that may include relief of pain or relief of the medical condition requiring controlled substances and/or improved physical or psychological function or ability to perform certain tasks or activities of daily living. This should also include any plans for further diagnostic evaluations and treatments, such as a rehabilitation program. From approximately January 1, 2016 through approximately June 30, 2018, the medical records from the period reflect repeated departures from the standard of care given Respondent's failure to document a specific treatment plan for this patient. The medical records did not have a clear plan or objectives for the ongoing prescribing of controlled substances.

66. Respondent's failure to document a specific treatment plan for this patient constitutes repeated extreme departures from the standard of care. There was no evidence to support that Respondent ordered any additional diagnostic evaluations or treatment for the patient related to the indications for prescribing the numerous controlled substances.

67. Under such circumstances, the standard of care requires that the medical records document that the physician discussed the risks and benefits of using controlled substances and other treatment modalities. An actual written consent is not required but is recommended. There was no evidence in the medical records that Respondent discussed potential side effects and risks of controlled substances. There were no written consent forms noted in the medical records. Respondent's clinical notes do not indicate that the risks of controlled substances were discussed. Failure to discuss the potential side effects and risks of ongoing prescribing of controlled substances with the patient constitutes an extreme departure from the standard of care.

68. The standard of care requires the medical records reflect that the physician is periodically reviewing the course of treatment and prescribing controlled substances for the patient, and making appropriate modifications in treatment based on the patient's progress or lack of progress. The medical records for Patient 4 fail to demonstrate that Respondent ever performed a periodic review on the patient's ongoing treatment with controlled substances even though the patient was prescribed multiple controlled substances over a period of over approximately two years. There were multiple extreme departures from the standard of care over

a period of approximately two years for failure to perform periodic reviews of the patient's treatment and status in the setting of repeated prescribing and refilling of multiple controlled substances.

69. The standard of care requires the physician consider obtaining additional evaluations and consultations, especially with complex pain problems. Special attention should be given to patients who are at risk for misusing their medication or have a history of drug addiction or substance abuse. Such patients require extra care and monitoring and documentation, and consultation with an addiction medicine specialist and, if indicated, a pain management specialist. There is no evidence in the medical records that Respondent had made any referrals or obtained a consultation related to prescribing the controlled substances for this patient. There is no evidence that Respondent assessed the patient for any prior history of drug addiction or substance abuse.

70. Respondent's failure to obtain a consultation in this patient was a simple departure from the standard of care.

71. The standard of care requires the physician to maintain accurate and complete records, demonstrating a history and exam along with evaluations and consultations, treatment plans and objectives, informed consent, medications prescribed, and periodic review documentation. The medical records for all visits by Patient 4 are largely illegible in all sections of the progress note. Likewise, the review of systems and physical examination sections of the progress notes were largely illegible, making it impossible to determine why the patient was being seen, what part of the physical examination was performed and what the specific assessment and plan of care was for the patient. The records lacked medical indication for the medications prescribed over a period of over approximately two years.

72. Respondent's failure to document standard guidelines in the use of controlled substances for Patient 4 was an extreme departure from the standard of care.

73. Respondent's treatment of Patient 4 caused harm. The inappropriate prescribing of controlled substances (in this case, clonazepam and hydrocodone) by Respondent without proper justification or medical indication for such substances over a period of approximately three years led to placing Patient 4 at an unnecessarily increased risk for significant morbidity and mortality

and potential harm given her pre-existing chronic medical conditions. Patient 4 had a history of anxiety and back pain. She was prescribed multiple controlled substances by Respondent that had high potential for abuse and dependency in a patient with multiple medical conditions who is at risk for exacerbation of said co-morbidities by taking unnecessarily prescribed controlled medications. This resulted in Patient 4 developing a dependency on multiple controlled substances that were prescribed without medical indication. Patient 4 unnecessarily developed a dependency on multiple controlled substances, which should not have been prescribed to her given the lack of medical justification or medical indication for inappropriately prescribing of such medications by Respondent.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

74. By reason of the facts set forth in paragraphs 16 through 30 (Patient 1), 31 through 47 (Patient 2), 48 through 61 (Patient 3), and 62 through 73 (Patient 4) above, Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he committed gross negligence in his care and treatment of Patients 1, 2, 3, and 4 as follows:

75. The facts and allegations in paragraphs 16 through 73, above, are incorporated by reference and re-alleged as if fully set forth herein.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

76. By reason of the facts set forth in paragraphs 16 through 30 (Patient 1), 31 through 47 (Patient 2), 48 through 61 (Patient 3), and 62 through 73 (Patient 4) above, Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts in his care and treatment of Patients 1, 2, 3, and 4, as follows:

77. The facts and allegations in paragraphs 16 through 73, above, are incorporated by reference and re-alleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

78. By reason of the facts set forth in paragraphs 16 through 30 (Patient 1), 31 through 47 (Patient 2), 48 through 61 (Patient 3), and 62 through 73 (Patient 4) above, Respondent is subject to disciplinary action under Code section 2266 for failure to maintain adequate and accurate records of patient care in his care and treatment of Patients 1, 2, 3, and 4.

79. The facts and allegations in paragraphs 16 through 73, above, are incorporated by reference and re-alleged as if fully set forth herein.

//

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination and Medical Indication)

80. By reason of the facts set forth in paragraphs 16 through 30 (Patient 1), 31 through 47 (Patient 2), 48 through 61 (Patient 3), and 62 through 73 (Patient 4) above, Respondent is subject to disciplinary action under Code section 2242 for prescribing controlled substances without an appropriate prior examination and medical indication to Patients 1, 2, 3, and 4.

81. The facts and allegations in paragraphs 16 through 73, above, are incorporated by reference and re-alleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing of or Administering of Drugs)

82. By reason of the facts set forth in paragraphs 16 through 30 (Patient 1), 31 through 47 (Patient 2), 48 through 61 (Patient 3), and 62 through 73 (Patient 4) above, Respondent is subject to disciplinary action under Code section 725 for repeated acts of clearly excessive prescribing or administration of drugs to Patients 1, 2, 3, and 4.

83. The facts and allegations in paragraphs 16 through 73, above, are incorporated by reference and re-alleged as if fully set forth herein.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

84. By reason of the facts set forth in paragraphs 16 through 83, above, Respondent is subject to disciplinary action under Code section 2234 for unprofessional conduct in his care and treatment of Patients 1, 2, 3, and 4.

85. The facts and allegations in paragraphs 16 through 83, above, are incorporated by reference and re-alleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 46373, issued to Respondent Moshen T. Moghaddam, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering him to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code;

4. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: MAR 24 2021

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

LA2021600806